Table 1. Health Indicators throughout the Life Span: Comparison of District of Columbia Residents to United States Population, 1999

Indicator	District of Columbia	United States
Percent of births with prenatal care beginning in the first trimester	70.6	83.2
Low birth weight: percent of live births	13.3	7.6
Infant mortality rate per 1,000 live births	15.0	7.1
Deaths from heart disease*	286.5	265.9
Deaths from cancer*	260.5	201.6
Deaths from cerebrovascular disease*	55.3	61.4
Deaths from HIV/AIDS*	49.3	5.4
Deaths from hypertension*	43.2	6.2
Deaths from diabetes*	43.0	25.1

*Crude death rate per 100,000 estimated population.

Table Source: District of Columbia Department of Health, State Center for Health Statistics Administration, Vital Statistics Data Sheet, 1999 (includes both District and U.S. data).

Condition of the Health Care Delivery System

To improve these health indicators, the gaps, deficiencies, and imbalances in the District of Columbia's health care system need to be addressed.[3] One of the key problems in the District is the lack of community-based medical homes for many of the city's uninsured and underserved residents.[4]

Background on Recent Developments

About two years ago, the Mayor decided to address the problems plaguing the health care system and D.C. General Hospital. First, he appointed a Health Care System Development Commission to develop recommendations and an implementation plan for changes to the health care system in the District. Following the Commission's work, a series of public forums, and much discussion among stakeholders and policy makers in the District, the city decided to fundamentally restructure the health care delivery system. One of the major pieces of the reform was to shrink and restructure

[3] Much of the following discussion is based on background research done for the Health Care System Development Commission, some of which appears in the District of Columbia's report, *Strategies for Change*. Health Care System Development Commission. Final Report. December 2000. See also *Improving Health Care Access for the Poor: A Case Study of the Washington, D.C. Public Health Care Systems Reform* presented at "Managing Health Systems for Better Health: The Stewardship Function of Health Ministries," Europe and the Americas Forum on Health Sector Reform, Malaga, Spain, February 24-27, 2002 (IESE and the World Bank).

[4] "Medical home" is defined as an individual's regular source of primary and preventive care that also provides an entry point to access diagnostic testing, hospital services, and other necessary and appropriate health care services.

D.C. General hospital, the major safety net hospital in the city and the focus of public dollars expended on healthcare (other than for Medicaid).

About four years prior to this, the Public Benefit Corporation (PBC), a quasi-public entity, had been created by the D.C. City Council in August of 1996 to oversee D.C. General Hospital, the public health clinics, and the school health system. While the PBC was created to oversee an integrated delivery system, the focus of the PBC remained on D.C. General, which was experiencing serious financial problems and drawing large subsidies from the city to stay solvent. Although patients who were part of the PBC system did generally have access to a range of primary, secondary and tertiary care, there remained many uninsured District residents who still did not have adequate access to care.

Many of the health indicators in the District, which were often well below national averages as noted above, showed that District health needs would be better met with better access to primary and preventive care. In addition, with the introduction of Medicaid managed care in the District and the shift from a focus on hospital-based services to more primary and preventive care, the need for hospital care declined and the need for a community-based primary care system became more evident. Faced with concerns about how to continue to fund D.C. General, and with a desire to focus public dollars on primary care, the city decided to fundamentally restructure D.C. General hospital and create the D.C. Healthcare Alliance.

Creation of the D.C. Healthcare Alliance

The D.C. Healthcare Alliance is a new program intended to provide a medical home and continuity of care for much of the city's indigent population.[5] Uninsured District residents with incomes at or below 200 percent of the federal poverty level are eligible to enroll. Alliance enrollees are eligible to receive primary care, specialty care, acute care and ancillary care services, and there are no co-payments or premiums required.

On April 30, 2001, the contract between the District and the D.C. Healthcare Alliance was finalized, and over the course of the next several months, health services previously provided by the PBC were shifted to Greater Southeast Community Hospital, Unity Health Care, Children's National Medical Center, and the George Washington University Hospital. Greater Southeast is the lead

organization in the Alliance, providing the bulk of hospital services and managing the day-to-day operations of the Alliance; Unity Health Care (a federally qualified primary care provider with sites across the city) oversees the six community health centers previously run by the PBC; Children's National Medical Center provides pediatric inpatient and ambulatory services and manages the school health program; and George Washington Hospital provides trauma services and tertiary care to supplement what is offered by Greater Southeast. While most services at D.C. General were closed, the hospital has continued to provide some emergency, urgent care, and outpatient services, and provides intake and referral for the Alliance. In addition, Greater Southeast Community Hospital has contracted with Chartered Healthcare Plan, a managed care organization, to provide administrative services, such as enrollment, care coordination, utilization management, and quality control, for the Alliance.

The Alliance is overseen by the Healthcare Safety Net Administration, which is located at the Department of Health. The Mayor also has established a Health Services Reform Commission (comprised of community leaders, health providers and planners, national health experts, and consumers) to track the Alliance's progress. As of February 14, 2002, an estimated 23,643 people were enrolled in the Alliance.[6]

The Reality: A Fragmented Delivery System

For many, however, the District has not had a well-functioning delivery system. While significant steps have been made in that direction, there is still much work to be done. The District's health care system is plagued with huge pockets of deprivation. There are shortages of physicians and other medical personnel east of the Anacostia River. Minority physicians are in short supply. Some physicians have relocated their practices to Maryland or Virginia. Some areas of the city do not have an accessible community health center.

Nearly one out of six District residents is uninsured (approximately 71,890 in 1999-2000[7]). This is always a problem, but it creates a particular hardship in Washington where the delivery system is fragmented and incomplete. At the first-level of the medical home, grassroots front-line, door-to-

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[5] Information about the D.C. Healthcare Alliance taken from testimony presented to the Committee on Human Services, Council of the District of Columbia, Hearing on the Status of the D.C. Healthcare Alliance Transition, June 22, 2001 (for a complete list of witnesses, see Source List at end of document).
[6] D.C. Healthcare Alliance Newsletter, February 2002.
[7] Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 and 2001 Current Population Surveys (from www.statehealthfacts.kff.org).

door care is under-developed, with the notable exception of a successful pediatric van and some work that has been done around school-based health care. At the second level of this model, many of the uninsured are served by about 60 community health centers. These centers struggle to meet the needs of both Medicaid and uninsured patients. But they are under-staffed, occupy facilities that are in need of repair and modernization, have a varied mix of management information systems, and are frequently operating without clear pathways to secondary and tertiary care. The primary care clinics are not well organized into a citywide system although certain umbrella organizations provide some helpful coordination. Some clinics are specialty facilities and do not see patients with all types of conditions.

At the third level, urgent care centers supplementing primary care with specialists, radiology, pharmacy, and advanced diagnostic equipment are few and far between. In short, the safety net providers are not integrated into a smoothly functioning integrated delivery system.

In addition to having a difficult time accessing health care, uninsured patients often cannot obtain the prescription drugs needed to adequately treat their conditions. While there are a variety of ways

ELEMENTS OF MODEL MEDICAL HOME

In a well-functioning primary care system, the basic unit of service is often a community-based medical home that emphasizes primary and preventive care services. A fully developed system of medical homes serving vulnerable populations may be depicted as a continuum, starting with mobile vans and small sites located in shelters, churches, and other locations to meet patients' most basic needs. The next step along the continuum consists of small clinics that provide the full scope of primary care services to adults and children. These often have exam rooms, a small laboratory, small dispensary, administrative space, and support services such as mental health and social services, but not on-site ancillary and urgent care services. Patients might go to these clinics or see primary care physicians in office-based group practices. Further along the continuum are urgent care centers providing all of the services available at community-based medical homes with the addition of on-site laboratory, radiology, and pharmacy services. These facilities have extended hours and serve as a hub for the community-based homes.

To ensure access to care for all residents, regardless of their neighborhood, these facilities need to be located throughout the city, staffed by culturally competent physicians and allied medical personnel, and provide 24-hour coverage in one form or another.

A well-functioning system also requires that when physicians working in these settings determine that a patient needs further medical attention involving referrals to specialists, diagnostic testing, or surgery, they can arrange for timely referrals to avoid dangerous delays in follow-up care. This requires relationships between the various components of the medical home and the secondary and tertiary levels of care.

Finally, a well-run system has accountability for cost and quality. This means that government purchasers of care for lower-income populations need a funding stream for the uninsured and a seamless, integrated system in which people enrolled in the State Children's Health Insurance Program (S-CHIP), Medicaid, and the uninsured are all given medical homes and enrolled in managed systems of care. As part of a procurement process to secure those services, the public buyer includes a requirement that providers and health plans develop standards related to quality.

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in which the uninsured obtain prescription drugs, the sources do not match needs sufficiently. If providers cannot secure the needed medications at the time the patient is seen and patients are forced to go to pharmacies, they may not fill the prescriptions or take less of the drug than medically indicated to stretch out the supply. Alternatively, physicians may be forced to provide less effective, older medications because those products are less expensive and therefore are the only ones available, or switch patients to different medications based on what samples or donations are available. Clearly, the lack of pharmaceutical access has implications for the health (and perhaps quality of life) of the patient, and that is particularly troublesome in a place like the District with high rates of chronic conditions such as asthma and diabetes that often can be treated effectively with good pharmaceutical management.

Understanding how the uninsured access drugs in the District will demonstrate the magnitude of the unmet need. A recent study by the Non-Profit Clinic Consortium outlines the current mechanisms by which uninsured patients obtain prescription drugs through the District's 13 non-profit clinics.[8]

- Patient Assistance Programs: These programs, the largest source of pharmaceuticals for uninsured District residents, are funded by pharmaceutical manufacturers and provide between $705,000 and $800,000 in drug assistance per year.

- Donations/Samples: Clinics receive donations from local private physicians and, although data are hard to obtain, the estimated value of those donations is approximately $185,000 per year.

- Purchase by Clinics: Clinics spend about $450,000 per year of their own funds to purchase pharmaceuticals to supplement other sources (this number, however, only includes purchases from 11 of the 13 District clinics, and is therefore probably an underestimate).

The same study estimates that it would take an additional 25 percent in funds, *or a total in excess of $1.6 million*, to provide pharmaceuticals to the uninsured in the District.[9]

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[8] The following numbers are taken from: Non-Profit Clinic Consortium. *An Analysis of Clinic Prescription Drug Needs and Their Financing.* Washington, D.C., April 2002.

[9] One recent program that is no longer funded is the Prescription Drug Purchase Assistance (PDPA) program. It was run by one of the clinics and was the result of a class action lawsuit settlement with pharmaceutical manufacturers that funded the purchase of prescription drugs from September 1999 through early 2001. While the PDPA program did temporarily alleviate the problem of access to pharmaceuticals, there has been nothing implemented to replace it, and now patients and providers are back to where they were before the program began.